

Child Neglect in the sub-Saharan

Title: Protecting Children from Nutritional and Medical Neglect in sub-Saharan Africa

Introduction

This study focuses on the dominant definitions of nutritional and medical neglect used to identify child maltreatment. These originate from the United Kingdom and the United States, but are also utilised in the developing countries of the sub-Saharan region. Evidence adduced from secondary data gathered in five representative African countries seeks to demonstrate that the application of these dominant definitions of neglect is misleading in the socio-economic context which pertains in most of the sub-Saharan region. The statutes which domesticate the *Convention on the Rights of the Child* (CRC) in these African countries are examined to reveal some distinctive national variations in their child protection provisions. While predominantly reflecting Western definitions of neglect, some of the legal provisions embedded in African domestic laws offer insights into more functional concepts of child neglect. Notably some recognise a tension between deprivation which denies parents the resources to satisfactorily care for their child, and neglect whereby adequately resourced parents deny their child nourishment and medical assistance.

International Law and Child Protection

The *Convention on the Rights of the Child* (CRC), ratified by the General Assembly of the United Nations, which came into force in 1990, compels States Parties to domesticate it through national legislation. Under art.19 States Parties are obliged to adopt legal measures to protect children from abuse and neglect by their parents or guardians. Art.24 requires States Parties to implement measures to: reduce child mortality; make available health care; combat disease and malnutrition; and provide basic knowledge to families about child health. As

signatories to the Convention, governments across the sub-Saharan region have now introduced national legislation to safeguard children. But given the indigent circumstances of most African families and the degraded health care systems of African nations, these two Convention articles are in tension with each other, for on the one hand art.19 implies duties held by parents to look after their children to a minimum standard, and on the other art.24 places an onus on African governments to make available public goods which promote child survival and development.

This tension is sometimes recognised, sometimes ignored, in the domestic legislation of sub-Saharan countries. Either way it is intensified by the dissemination of ethno-centric conceptions of child abuse and neglect emanating from France, the United Kingdom and the United States, which have historically shaped social work practice in African countries and which continue to do so (Midgley, 2008; Rankopo & Osei-Hwedie, 2011). The five developing African countries comprising this study are all former colonies of what was the British Empire. Not only did social work in these countries replicate that in the United Kingdom, but the decision of most post-independence countries to adopt English as the official language led to the continued influence of British and American text books in social work training and practice (Laird, 2008; Mwansa, 2011).

In the social work literature of Britain and America, the two countries which have dominated English language social work on the African continent, there are six major categories of child neglect, which are physical, supervisory, educational, emotional, nutritional and medical (Horwath, 2007:27). Evidence of these forms of neglect has centred on respectively: poor hygiene; inadequate supervision; school absenteeism; parental unresponsiveness; low weight-for-age (often associated with non-organic failure to thrive); and delay or failure of parents to seek medical attention for a child's illness (Carter & Bannon, 2003; Jenny, 2007; Horwath, 2007; Batchelor, 2008; Giardino et al., 2010; Lowen, 2011; Daniel, et al., 2011). These are

primary indicators of neglect according to British and American scholarship and therefore bear interrogation when transplanted to a sub-Saharan setting. This study focuses on life threatening parental behaviour in relation to nutrition and medical neglect. The central contention of this study is that the notions of child neglect embedded in social work practice and framed by the domestic laws of many Anglophone sub-Saharan nations derive from essentially Anglo-centric preconceptions of child protection and are particularly misleading given the impoverished circumstances of African populations. They also divert attention away from central and local government responsibilities for the welfare of children, and in a developing country context, the wider responsibilities of the international community to assist African nations under art.24 of the *Convention on the Rights of the Child*. All the statutes domesticating the CRC examined in this study refer to nutritional and medical neglect. However, as table 1 below illustrates, different countries have taken divergent views on whether or not malnourishment and poor medical care are solely to be attributed to parental behaviour or implicate wider governmental responsibilities. Taken together, these statutes incorporate three divergent conceptions of neglect, which raises the question as to which, if any, serves to best protect children from inadequate medical care or diet.

[Table 1: National Child Protection Laws]

Methodology

The study examines child protection legislation domesticating the CRC in five Anglophone sub-Saharan countries. By selecting nations ranked between 125 and 155 on the human development index, the case studies reflect the range of socio-economic conditions typical of

low income countries in the region (UNDP: 2011: table 1). Table 2 below summarises key human development indicators for these five countries and includes those of the United States and the United Kingdom for comparative purposes. The inclusion of two Southern, two Eastern and one Western African nation also permits the exploration of the commonality of socio-economic conditions, not only in the countries directly considered, but by inference to most of the sub-Saharan region. Country-specific secondary data is drawn predominantly from the Demographic and Health Surveys which are conducted periodically in most sub-Saharan countries. These consist of directly comparable data sets collected through national standardised survey formats which enquire into the nutritional, health, housing and income status of households. Data from these surveys is supplemented by evidence from smaller scale qualitative and quantitative studies undertaken in each of the five countries under examination in order to interrogate the household factors which lie behind the headline figures of the Demographic and Health Surveys. The contributory factors to the under nourishment and inadequate health care of children emerging from this research literature are examined in relation to parental neglect. The countries have also been selected on the basis of a range of rankings concerning the efficacy of their child protection systems and the child-centeredness of their policies, as illustrated in the final two columns of table 2 below.

[Table 2: Human Development Indicators]

Research on Neglect in Africa

Child neglect, once an area of intense scrutiny during the 1960s and 1970s, has long been eclipsed by the plethora of research and deliberation on the physical and sexual abuse of

children in both the United States and the United Kingdom (Smith & Fong, 2004; Horwath, 2007). The preoccupation with child physical and sexual abuse is equally discernable among the less numerous studies of child maltreatment in the sub-Saharan region (Rwezaura, 1998; Obisesan, et al., 1999; WHO, 2002; Lalor, 2004a, 2004b; Mildred & Plummer, 2009; Frankenberg et al., 2010; United Republic of Tanzania and UNICEF, 2011). Even where neglect is acknowledged as a distinct category of maltreatment, it is often either subordinated to, or largely subsumed within, wider considerations of sexual or physical abuse (Korbin, 2002; Pierce & Bozalek, 2004; Sossou & Yogtiba, 2009). In short, neglect does not emerge from the African literature on child maltreatment as either a distinct or pertinent subject for research. This is despite the paucity of data on child neglect in developing countries identified by the WHO (2002:60) a decade ago and its exhortation for research to be carried out into this phenomenon. Even WHO (2002:65-69), for all it initially differentiates child neglect as a specific category of maltreatment, then proceeds to cite research which treats it as undifferentiated from other forms of harm. UNICEF (2008), the United Nations agency charged with responsibility to support the development of child protection systems worldwide, completely omits neglect from its Medium Term Strategic Plan for 2006-2013, which instead focuses on eliminating the sexual and physical abuse of children. Yet child neglect continues to feature in the legislation of African nations and hence on the curricula of African social work training courses.

Poverty, Food Insecurity and Malnutrition

As indicated in table 2 above, extreme poverty, as measured by the international poverty line of \$1.25 per day per for an adult, characterises the living conditions of between 20% and 90% of households across the five countries included in this study. The widespread dependence of populations on rain-fed small scale subsistence cultivation means that extreme poverty,

comparable to conditions of absolute poverty, is concentrated in rural areas (World Bank, 2007). Since 70-85% of the population in the five countries comprising this study live in rural areas, these conditions pertain for the vast majority of households (see table 2 above). Exceptionally, Nigeria has around 50% of its population living in rural areas, which nevertheless remains in sharp contrast to a 15% average for those of developed countries (UNDP, 2011: table 10). Data from the national Demographic and Health Surveys for all five countries indicates gross disparities in levels of childhood malnutrition with the incidence of stunting (indicative of inadequate nutrition over a prolonged period) among under-fives ranging as high as 44-56% among the lowest wealth quintile, but still as high as 24-36% among the highest quintile in the populations under study, indicating the extent to which those in higher income groups in the sub-Saharan are still impoverished relative to their middle-class counterparts in the United Kingdom and the United States. The contrast between higher and lower income quintiles is even starker in relation to children's weight-for-age. The incidence of wasting among under-fives (a measure of acute malnutrition in the period leading up to the Demographic and Health Survey due to illness or inadequate food consumption) ranged from 17-48% in the lowest quintile and 7-10% in the highest (KNBS & ICF Macro, 2010:Table 11.1; NPC & ICF Macro, 2009:Table 11.1); NBS & ICF Macro, 2011:Table 11.1; NSO & ICF Macro, 2011:Table 11.1; UBS & Macro International Inc., 2007:Table 11.1).

In Kenya food insecurity is experienced by 38% of urban households and 51% of rural households (UNDP Kenya, 2006:8). Most of this comprises of transitory food insecurity attributable to 'inadequate access to food due to instability in food production, food supplies and income' while in rural areas additional contributory factors include 'lack of credit services, illiteracy and poverty' (UNDP Kenya, 2006:8). As a consequence almost 50% of the Kenyan population is undernourished (UNDP Kenya, 2006:8). Some national surveys report

prevalence rates of micronutrient deficiencies among children under three as high as 77% (Semproli & Gualdi-Russo, 2007:463). These are also observable among large sections of school-aged children, particularly in relation to iron (Leenstra et al., 2004; Murphy et al., 2007). Deficiency of iron folate and vitamin B12 in children's diets results in low levels of haemoglobin in the blood, reducing the uptake of oxygen by vital organs and ultimately causing impaired cognitive and motor development. Similar findings emerge from the Demographic and Health Surveys of other countries included in this study (KNBS & ICF Macro, 2010; NPC & ICF Macro, 2009; NBS & ICF Macro, 2011; NSO & ICF Macro, 2011).

While insufficient food consumption is certainly one cause of micro-nutrient deficiencies, persistent disease among children also explains their failure to metabolise nutrients when these are available. In particular 'childhood diseases such as malaria, diarrhoea, acute respiratory infection, and measles aggravate the nutritional problems by impairing intake and utilisation of nutrients, lowering the body's defence system thus predisposing the body to other infections and increasing requirements for other nutrients' (Mosha et al., 2000:186). Results found elsewhere in the sub-Saharan region indicate that infection rates among children may be more significant than seasonal shortages of food in degrading their nutrition (Sellen, 2000). Childhood malnutrition is reckoned to be a primary causal factor in half of all under-five deaths in sub-Saharan Africa (Pelletier et al., 1995). It contributes to the one-in-five deaths of under-fives in Malawi and almost one-in-ten deaths in Kenya (see table 2 above).

Detecting Nutritional Neglect

In the United States and the United Kingdom the detection of nutritional neglect relies primarily upon the administration of Centile Charts which tract a child's physical growth against standardised age related developmental expectations in terms of height and weight (Carter & Bannon, 2003; Bachelor, 2008). A young child whose weight or height falls below that anticipated is likely to be medically examined to establish if there is an organic cause. Child protection procedures will be invoked where no organic cause is detected, the assumption being that under-nutrition is attributable to abusive or deficient care (Horwath, 2007; Batchelor, 2008). The WHO (2007) has devised international standards for height-for-age and weight-for-age. But the preponderance of stunted and wasted children due to conditions of absolute poverty, the food insecurity endemic to dependence on small rain-fed agricultural holdings and widespread micronutrient deficiencies caused by reliance on staples together with high infection rates calls into question what Centile Charts can actually detect.

In the relatively prosperous nations of the USA and the UK non-organic malnutrition can very quickly be attributed to cruelty or problematic parent-child interactions around feeding because food is plentiful and accessible. This contrasts sharply with the living conditions of the majority of rural households and a high proportion of those in urban areas as the evidence above attests. Many scholars in America and Britain have linked poverty to child neglect (Drake & Pandey, 1996; Coulton, et al., 2007; NSPCC, 2008). Internationally renowned organisations such as the Child Poverty Action Group (CPAG) and the National Society for the Prevention of Cruelty to Children (NSPCC), which highlight the correlation between poverty and neglect, have campaigned for many years for government policies to lift families out of low income as a means of reducing the incidence of neglect. Nevertheless, the dominant discourse in the UK and the USA continues to orient the prediction, detection and prevention of neglect around individual and family factors (Hobart & Frankel, 2005:34-40;

Horwath, 2007; U.S. Department of Health & Human Services, 2006; Giardino, et al, 2010).

Influential models of child neglect, which differentiate out risk factors, reflect the dominant paradigm, which construes structural factors as distal risks and parental behaviour and the home environment as proximal risks (Slack et al., 2003). Consequently poverty is assumed to be associative with nutritional neglect while the behaviour of parents is deemed causal and therefore constitutes the primary site of scrutiny, assessment and intervention.

Uganda's Children Act 1997 sets out the criteria for making a Care Order to remove a child into State care on the same basis as that contained in Britain's Children Act 1989. Similar statutory provisions appear in the other four statutes. Section 21 of the Children Act 1997 stipulates that a Care Order can be made if 'the child concerned is suffering or is likely to suffer significant harm; and that the harm, or the probability of harm, is attributable to the care given to the child, or likely to be given to the child if the order were not made, not being what it would be reasonable to expect a parent to give to a child'. Malnourishment so severe that it retards development, causes physical and mental impairment and exposes children to repeated infections because of their physically weakened condition is patently 'significant harm'. But whether it is attributable to parental care not being that which a reasonable parent would give is a moot point. In the circumstances of acute deprivation which characterise living conditions of large swaths of African populations, Anglo-centric notions of neglect break down because it is a concept which essentially excludes structural causation. A reasonable parent enduring conditions at or near absolute poverty is by definition unable to meet the nutritional needs of their child.

Childhood Illnesses

Logan (2008), in a secondary analysis of global epidemiological data, found that in Africa the main causes of under-five deaths were attributable to diarrhoea in 18% of cases, pneumonia in another 19% and under-nutrition in 50% of instances. All of these conditions are preventable either with good nutrition or appropriate medical treatment. Logan's (2008) findings highlight: the susceptibility of children in sub-Saharan countries to opportunistic infections when they are already physically weakened by malnourishment; the imperative of preventative health care; and the rapid remedial action required of parents to childhood illness. For this reason all of the national Demographic and Health Surveys conducted in the five countries under study examined the prevalence and treatment of the symptoms associated with the major killer diseases of young children. Their prevalence is indicated in table 3 below.

[Table 3: Percentage of under-fives suffering from illness in the two weeks prior to the survey]

To take just one example, in terms of remedial treatment for a potentially life threatening childhood illness such as diarrhoea, table 4 below details home care by parents or guardians. The correct treatment for diarrhoea is to ensure that a child receives more liquid than usual. Giving a child less liquid can result in severe dehydration and death. As might be expected parents in rural areas were more likely than their urban counterparts to provide their children with less liquid, as were parents from lower wealth quintiles. But what is striking about the results from the Demographic and Health Surveys in the table below is the high proportion of parents in all countries and across both geographical location and wealth quintiles who were giving their children less liquid, directly imperilling their health. This finding seems to point

to cultural influences or weaknesses in public health education as opposed to careless or negligent responses by parents to the needs of their children.

[Table 4: Percentage of under-fives suffering from diarrhoea given less liquid during the two weeks prior to the survey]

Health Care

The home care of ill children by their parents is not the only issue. Most sub-Saharan populations have poor access to medical services compared to those of the United States and United Kingdom. For example Malawi, Tanzania, Uganda and Kenya respectively have just 0.02, 0.02, 0.08 and 0.14 physicians per 1,000 people compared to 2.3 in the United States and 2.2 in the United Kingdom. The figures for nurses evidence the same gross differential with Tanzania, Uganda and Kenya having respectively 0.35, 0.72 and 1.14 nurses per 1,000 of population compared to 8.1 for the United States and 8.8 for the United Kingdom (Kinfu, et al., 2012; NationMaster.com, 2012; World Bank, 2004:3). But paucity of health care workers is not the only problem for families in need of medical attention for an ailing child.

UNDP Kenya (2006:7), drawing on a plethora of research, concluded that the vast majority of poor families could not afford the charges levied at public health facilities and that recurrent shortages of drugs led many adults to use traditional medicines. Even where drugs were available, examination of service quality conducted at district level revealed the failure of medical staff to identify and/or correctly treat common conditions such as clinically severe malnutrition and fever in children (Nzioki, et al., 2009; Lindblade, et al., 2007; English et al., 2004). Similar findings emerge for services in Uganda; for example, 60% of health workers did not check children's temperature on admission while 80% checked neither their

respiratory rate nor for dehydration (Witter & Osiga, 2004). In Nigeria too the shortage of essential drugs and the variable quality of treatment at primary care level for children acted as a disincentive for parents to access provision (Ehiri, et al., 2005). Likewise in Malawi a United Nations assessment concluded that despite progress in some areas of the country, the health system comprised of an ‘aging and dilapidated health infrastructure’ magnified by a chronic shortage of medical staff and concerns as to the competence of existing health care workers (United Nations, 2010:10).

Research across the five countries in this study indicates that long distances or dilapidated roads to the nearest clinic together with the unavailability of routine drugs, deters or delays parents, particularly in rural areas, from attending medical facilities for their children (Witter & Osiga, 2004; Feikin, et al., 2009; Kahigwa et al., 2002; Agee, 2010). Unofficial charges levied by doctors and nurses, where health services were notionally free, also discourages the use of health services (Witter & Osiga, 2004). Even in Kenya’s urban slums where families lived in proximity to health facilities, 40% of parents still failed to seek medical assistance, with half of them attributing this to the prohibitive cost of treatment. Household income was significantly associated with accessing health facilities (Taffa & Chepnego, 2005). Similar results are reported for Nigeria and Uganda with low income and the cost of accessing treatment constituting a major disincentive to availing of health care services both in urban and rural areas (Tinuade, et al., 2010; Onwujekwe et al., 2010; Rutebemberwa, et al., 2009; Ettarh, et al., 2011).

Detecting Medical Neglect

Drawing on the wider literature Horwath (2007:27) defines medical neglect as occurring ‘when carers minimise or deny a child’s illness or health needs, fail to seek appropriate

medical attention or neglect to administer medication and treatments'. This is a problematic definition in the context of sub-Saharan Africa. Infections are much more frequent among the children of sub-Saharan populations and a number of common conditions are life threatening. The evidence from national Demographic and Health surveys suggests that a large proportion of parents provide treatment which exacerbates the child's illness or else they delay or entirely fail to seek medical advice despite the potentially lethal consequences for their child. Inadequate public health information together with the costs, geographic inaccessibility and poor quality of health provision appear to account for the large numbers of African parents who do not seek, or delay in seeking, medical treatment for their child. Anglo-centric definitions of medical neglect create two major problems in a sub-Saharan context. Firstly the large proportions of parents failing to provide appropriate medical care due to a range of structural factors makes it virtually impossible for social workers to actually disaggregate the individual parent wilfully engaged in the medical neglect of their child from the parent struggling with overwhelming obstacles to the effective health care of their child. Secondly, the typical signs of medical neglect such as frequent and untreated infections, delay or failure to seek medical advice are profoundly misleading ones given the background to childhood illness and health care in a sub-Saharan context.

Societal Neglect

Societal or collective neglect is a conceptualisation of child maltreatment which focuses on the conditions created for parents and children by macro level political, economic and social forces. Attention centres on how income inequalities, the provision of public goods and cultural norms impact on children's care within the family. As the British scholar Horwath (2007:39) acknowledges, 'only a minority of definitions recognise societal or collective

neglect’, a view echoed by Smith & Fong (2004) in their edited volume of American scholarship on child neglect. Nevertheless it is recognised in WHO (2006), a document intended to inform child protection worldwide. According to WHO (2006:13) societal neglect refers to ‘the underlying conditions of society that influence maltreatment – such as...economic inequalities and the absence of social welfare safety nets’. In an earlier publication WHO (2002:60) defined child neglect as ‘the failure of a parent to provide for the development of the child – where the parent is in a position to do so’. Evidence presented above begs the question as to whether the majority of African parents are indeed ‘in a position to do so’ - to offer essential nutrition and basic health care to their children.

WHO (2006:13) presents an ecological model of child neglect with risk factors acting at four levels, the *individual* parent, their *relationships* with family and friends, the *community* in terms of neighbourhood and *society*. However, WHO (2006) does not deliberate on where the greatest or gravest risk factors lie in relation to these four levels. It therefore leaves unaddressed the priorities of intervention to prevent or curb child maltreatment. If it is the case that most parents are habitually not in the position to provide adequate nourishment and rudimentary health care to their children, what then are the implications for social work practice in the sub-Saharan region? In the United Kingdom and the United States child protection practice in relation to neglect has become exclusively concerned with the *individual* and *relationship* levels of risk and intervention. Should such a preoccupation characterise African social work also?

Reforming the Law on Child Neglect

With the exception of Nigeria’s Child’s Right Act 2003 which places duties on the State as well as parents or guardians to meet children’s basic nutritional and health care needs, all

other statutes examined in this study ignore the actions of government as a salient factor in the malnourishment of children and the inadequate medical attention given to them. Parents either hold an unqualified duty to provide these necessities for their children or else this duty is qualified by parents being in a position to provide them, but failing to do so. If children are to be effectively protected from malnourishment and illness, this necessitates a joint effort by the State and parents or guardians; a position clearly envisaged by articles 24 and 27 of the *Convention on the Rights of the Child* to which all African countries (excepting Somalia) are signatories. By adopting a legal definition of neglect, which sidelines poverty, the governments of such countries as Kenya, Tanzania and Malawi and others in the sub-Saharan region, replicate a social construction of maltreatment deriving from social work theory and practice in Britain and America, with minimal relevance to their own populations.

A change in the law to reflect the responsibilities of the State as envisaged in the *Convention on the Rights of the Child* need not open the floodgates to legal action by parents to compel highly indebted African governments to provide services they could not possibly afford (World Bank, 2011:table 5), were such a duty to be couched in terms similar to those of arts. 24 and 27 of the Convention. Article 27(3) requires States Parties to provide material assistance to families in relation to nutrition ‘in accordance with national conditions and their means’. Article 24(4) obliges the international community - meaning primarily post-industrial nations - to assist developing countries to meet the health care needs of children in their populations. The State’s duty to contribute to the nutrition and health care of children could thereby be qualified according to the availability of resources and subject to part funding by richer countries in the form of Overseas Development Assistance. This would limit legal action against the State, while recognising the impossibility for parents or guardians of providing their children with adequate nutrition and medical care in conditions approaching absolute poverty. Such an amendment to current laws would prevent a mismatched Anglo-

centric conception of neglect being used to justify unwarranted intervention in the lives of impoverished families in the sub-Saharan region.

Mulinge (2010) argues that while domesticating the CRC in African countries is crucial to creating a legal framework for the protection of children's rights, it can become an end in itself and a diversion from actual implementation. The gap between legislation and efficacious child protection was investigated by The African Child Policy Forum which devised a Child-Friendliness Index (CFI) based on over 40 policy and outcome indicators to interrogate the 'protection, provision and participation' given to children (Bequele, 2010); for example Nigeria has an index value of 0.768 for child protection, ranking it 9th on the continent. Yet despite the government's commitment set out in the Child's Right Act 2003 to health provision for children, its relatively small allocation of public expenditure to health services results in the country dropping down to 22nd on the CFI. By contrast Kenya, which like Nigeria, has a high child protection index value, also has a high CFI index because of its commitment to health provision (see table 2). Enacting child protection legislation, which acknowledges the role of the State - as opposed to only the parent - in child maltreatment, is patently just a legal starting point for addressing societal child neglect.

Reforming Social Work Practice

WHO (2006:table 3.1) delineates a number of broad strategies to reduce societal risk factors in child maltreatment. These include promoting social and economic rights while tackling poverty and income inequality, alongside the provision of early childhood education and care. The international definition of social work articulated by IFSW (2012) states that 'social workers are change agents in society and in the lives of the individuals, families and communities they serve...social work interventions range from the primarily person-focused

psycho-social processes to involvement in social policy, planning and development'. This suggests that African social workers have roles in relation to societal neglect at both a macro and micro level. At a macro level, their national professional associations ought to actively campaign for social justice focussed on improved health and welfare services for children. Social workers should move towards advocacy for the provision of essential public goods and accessible quality health care. At the micro level of family intervention, practice needs to centre on poverty alleviation through facilitating access to: supplementary food programmes to strengthen household food security; micro-credit to purchase essential goods and weather crises; intermediate technologies to improve the processing and preservation of food crops; and training in basic preventative health care and treatment of common, but life threatening, illnesses. These are of course very different practice imperatives from those of child protection social workers in the UK or the USA. But, as IFSW (2012) acknowledges, 'the priorities of social work practice will vary from country to country and from time-to-time depending on the cultural, historical and socio-economic conditions'. In sub-Saharan countries the socio-economic conditions of most families require a new departure in social work practice in order to best protect children.

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Tables for Inclusion

Table 1: National Child Protection Laws

Country & Statute	Nutritional Neglect	Medical Neglect
Kenya: The Children Act 2001	s.23 places an unqualified duty on parents to provide their children with an 'adequate diet'	s.23 places a duty on parents to provide their children with 'adequate medical care' s.9 places a duty for providing health and medical care on both the government and parents.
Nigeria: Child's Right Act 2003	s.13 places a duty to 'ensure the adequate provision of nutrition and safe drinking water' on the government s.14 places a general duty on parents to care for their children	s.13 government, services and parents are required 'to provide for the child the best attainable state of health' while the government is to 'ensure the provision of necessary medical assistance and health care services to all children'
Uganda: Children Act 1997	s.11 defines nutritional neglect as occurring where 'a parent...is able to but refuses or neglects to provide the child with adequate food'	s.11 defines medical neglect as occurring where 'a parent...is able to but refuses or neglects to provide the child with...medical care'
Tanzania: The Law	s.8 gives a child the right to food	s.8 gives a child the right to medical

of the Child Act 2009	which it is the duty of a parent to provide	care which it is the duty of a parent to provide
Malawi: Child Care Protection and Justice Act 2010	s.3 places a duty on parents to ensure the child's survival through providing him or her with an 'adequate diet'	s.3 places a duty on parents to ensure the child's survival through providing him or her with 'medical attention'

Table 2: Human Development Indicators

Country	HDI Rank	Percentage of population in rural areas	GNI per capita ppp 2008	Pop below ppp \$1.25 a day	Under 5 mortality rate per 1,000	Protection of children index values	Child- Friendliness Index (CFI)
Kenya	128	77%	\$1,628	19.7%	84	1	6
Nigeria	142	51%	\$2,156	64.4%	138	9	22
Uganda	143	86%	\$1,224	51.5%	128	12	21
Tanzania	148	73%	\$1,344	88.5%	108	14	23
Malawi	153	80%	\$ 911	73.9%	191	26	8
USA	4	17%	\$47,094	---	8	---	---
UK	26	20%	\$35,087	---	6	---	---

Source: UNDP (2011: tables 1, 4,5 & 10); World Bank (2011:table 3); Bequele (2010)

Table 3: Percentage of under-fives suffering from illness in the two weeks prior to the survey

Illness	Kenya	Nigeria	Uganda	Tanzania	Malawi
ARI	8	3	15	5	7
Fever	23	15	40	25	35
Diarrhoea	16	7	23	15	18

Source: UBS (2012:16); KNBS & ICF Macro (2010:Table 10.4, 10.5, 10.6); NPC & ICF Macro (2009:Table 10.11, 12.6, 10.8); NBS & ICF Macro (2011:Table 10.5, 10.6, 12.3); NSO & ICF Macro (2011:Table 10.6, 10.7, 10.10)

Table 4: Percentage of under-fives suffering from diarrhoea given less liquid during the two weeks prior to the survey

Country	Kenya	Nigeria	Uganda	Tanzania	Malawi
Urban	36	48	14	21	33
Rural	41	56	27	26	38
Lowest wealth quintile	36	59	28	30	41
Highest wealth quintile	39	47	22	19	31

Source: KNBS & ICF Macro (2010:Table 10.8); NPC & ICF Macro (2009:Table 10.13); NBS (2011:Table 10.8); NSO & ICF Macro (2011:Table 10.11); UBS & Macro International Inc. (2007:Table 11.9)